Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory **ARIZONA**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): **KIDSCARE**

SCHIP Program Type:
_____Medicaid SCHIP Expansion Only
X Separate SCHIP Program Only
_____Combination of the above

Reporting Period: **Federal Fiscal Year 2001 (10/1/2000-9/30/2001)**

Contact Person/Title: Cheri Tomlinson, Federal & State Policy Administrator

Address: AHCCCS, 801 East Jefferson, M D 4200, Phoenix, AZ 85034

Phone: (602)-417-4534 Fax: (602)-256-6756

Email: cktomlinson@ahcccs.state.az.us

Submission Date: _____

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

Effective for eligibility beginning October 1, 2001 the Arizona Legislature reduced the mandatory waiting period following voluntary termination of other creditable health insurance coverage from six months to three months. The same legislation added a waiver of the waiting period for seriously or chronically ill children.

B. Enrollment process

NC

C. Presumptive eligibility

NC

D. Continuous eligibility

NC

E. Outreach/marketing campaigns

The AHCCCS Administration, community organizations, and foundations, health plans as well as Indian Health Services (IHS) and Tribal agencies continue to expend diversified energy in their efforts to capture the varied cultural populations, which encompass KidsCare. (See Attachments A, A-1, A-2, and A-3 for a visual review by county and organization of outreach efforts.) (See also section 2.5 #2 for more detail.)

The AHCCCS Administration, in partnership with the entities noted above, have impacted the number of enrollments in the SCHIP and Medicaid programs because of the emphasis placed on outreach strategies. (See Attachment B regarding KidsCare application figures and Attachment C and D regarding Medicaid figures as a result of KidsCare.) The major outreach methods, innovations and successes are as follows.

Overview of strategies

AHCCCS has been increasing and strengthening its efforts. The social marketing outreach strategies conducted by AHCCCS include but are not limited to the following:

- One-on-one interventions (e.g., counseling and referral and event-based outreach);
- A referral hotline and information number (1-877-764-KIDS (5437);
- State wide community information forums;
- Mobilization of community coalitions:
  - Associations (Neighborhood Association and PTA meetings),
  - Counties,
  - Community health centers,
  - Chamber of Commerce, and
  - Children's organization;
- Training community advocacy groups regarding assistance to families in the

completion of the Universal Application;

- Information sharing with foundations (The Flinn Foundation and St. Luke's Charitable Trust);
- Inter relationships with:
  - Health organizations (hospitals, doctors, clinics, immunization clinics and events, and Arizona Rural Health Team), and
  - Tribal entities;
- Usage of mass media (TV and radio) and small media (brochures, flyers and posters);
- Small or large group interventions (e.g., events like health fairs, presentations, peer workshops, and lectures);
- Utilization of Community Based Organizations to perform outreach and application assistance;
- Partnerships with:
  - Sister state agencies (Department of Health Services, Department of Economic Security, and Department of Education);
  - Municipalities (City of Phoenix, City of Glendale);
  - Mexican Consulate;
  - Community organizations (Big Brother Big Sister Program, fire departments, events in malls);
  - State health iniativies such as Healthy People 2010; Arizona Community Action Association, Arizona Community Councils; Community Action Planning Grantees; Health Subcommittee of the Collaboration for a New Century;
  - Border health initiatives such as Border Fronteriza Project, Arizona Border Health Commission, Western Arizona Health Education Center Promotora Project; and
  - Ecumenical groups such as Arizona Ecumenical Council, Catholic Diocese of Phoenix, Southwest Human Development Council; and
- Collaboration with minority health groups – Concilio Latino de Salue; Asian-American Health Outreach Project, African –American Health Committee; and Inter-agency Farmworkers Coalition

Overview of activities

The following content areas describe various AHCCCS activities associated with the strategies previously noted.

Varied marketing techniques

The KidsCare Administration has hired four Regional Outreach Coordinators and an Outreach Manager to direct statewide outreach activities. Together these coordinators have developed an outreach plan, which includes:

- Supporting and collaborating with the community based organizations on outreach events and in setting up community coalitions *(mobilization & small and large group intervention),*
- Training and education *(small and large group intervention),*
  - Developing collateral materials
- Creating uniform outreach training materials *(small media*),
  - Powerpoint presentations to assist with training and outreach
- Developing a business packet to target the small business and minority business companies *(small media).*

Mobilization of community coalitions

AHCCCS and the community are intensifying their outreach efforts as evidenced by:

- The City of Phoenix Parks, Recreation and Library Administration recently agreed to pursue the following strategies:
  - Distribute KidsCare information to all of their part-time staff in four park districts because many are young people age 18 and under;
  - Distribute information at their after school programs that are located at 150 different

schools, (Each after school program site serves anywhere from 30 to 180 children);
- ◊ Allow KidsCare staff to speak at their next supervisor's meeting (200 people) which is scheduled for January;
- ◊ Review the intake form they currently utilize to collect information from the parents of the children that attend the recreation programs. Additional questions concerning access to health care will be included on the application;
- ◊ Have AHCCCS train their staff regarding the completion of KidsCare applications so that they can be taken onsite; and
- ◊ Insert information in the department's newsletter and in employee's paychecks.

- ♦ The City of Phoenix Manager's Youth and Education Office agreed to insert information concerning KidsCare in their newsletter that is distributed to all school principals in the City of Phoenix and Maricopa County.
- ♦ The Central Arizona Outreach Coordinator works closely with the Maricopa County coalition. The coalition is made up of grantees, health plans, community organizations and community volunteers who:
  - ◊ Share best practices, and
  - ◊ Attend and support:
    - ❖ Promotional events and sign up drives for KidsCare, and
    - ❖ Immunization and health fair events in their prospective locations around Maricopa County.
- ♦ The Southern Arizona Outreach Coordinator works close with the Tucson Coalition. This coalition is made up of grantee, and community volunteers, and community organizations. These members support the sign up events, and promote KidsCare at the community events.
- ♦ Arizona Asian Health Initiative Coalition--Ahcccs Community Relations Unit has worked closely with this Coalition to assist them in organizing as a group. AHCCCS also has assisted them in applying for several federal grants for family care and continues to be a part of this coalition.

Sister State Agency

- ♦ AHCCCS and the Department of Education (DOE) recently partnered to notify families of the KidsCare program through the Child Nutrition Program.
- ♦ AHCCCS printed and sent one million flyers to 381 school districts that participated the Child Nutrition Program.
- ♦ Families completed the simple form, answering three self-screening questions and returned it to the school if their child was uninsured, and they wanted an application mailed to them.
- ♦ To date, AHCCCS has received and responded to 18,274 requests for applications from 86 school districts.

Health Organization

AHCCCS has developed a universal application that includes Medicaid, SCHIP and state funded programs. Outreach staff have been trained regarding all programs. This will enable outreach staff to more effectively assist family members who may be eligible for other AHCCCS programs in tandem with their KidsCare outreach efforts..

Tribal Entities

AHCCCS is also working diligently to increase the enrollment of Native American families in both reservation and urban communities. The *KidsCare News* is a newsletter that provides KidsCare information that is of specific interest to tribal communities. The informative publication includes KidsCare updates, AHCCCS outreach efforts and events, tribal enrollment statistics as well as the KidsCare eligibility requirements and income limits. The AHCCCS Native American Coordinator provides opportunities for both communication and education and is a key link between AHCCCS and the twenty-one Tribes.

Mass media/small media

AHCCCS contracted with the media firm, Genesis/ Hill & Knowlton from January 1, through June 30, 2001. The media firm:

- Arranged for five sign up drive events around the state, two in Phoenix, and one each in Tucson, Flagstaff and Yuma;
- Promoted the program by radio extensively from April 23 to June 30 generating an increase in requests by phone for a KidsCare application;
- Promoted the program by newspaper ads in English and Spanish around the state; and
- Developed a new poster and brochure and modified the logo
  - The 800 number to request an application is part of the new logo.
- The newly developed brochure will enable the client to have two options to obtain an application.
- Call for an application; or
- Send in an attached postage paid post card to request an application.

Community Organizations: Strategies & Activities

Through a grant from the Flinn Foundation, Arizona State University (ASU) is currently compiling the outreach program data for Children's Action Alliance, Flinn Foundation and St. Luke's Charitable Trust. The summary report is expected at the end of the three-year projects. While it is too early for outcomes, these grants are allowing communities the opportunity to provide outreach that was previously unavailable.

- Children's Action Alliance (CAA)
  - CAA dispersed $1 million in grants from the Robert Wood Johnson Foundation to El Rio Community Health Center in Tucson, Phoenix Day School Health Links Project, and Yuma Department of Public Health. The purpose of these grants is to:
    - Decrease the number of uninsured
    - Increase access to care
    - Provide technical assistance in outreach
    - Produce publications
    - Increase collaboration

- Flinn Foundation

  In addition to the evaluation grant to ASU, the foundation has awarded KidsCare outreach grants totaling $130,825 to Children's Action Alliance in Phoenix, Interfaith Cooperative Ministries in Phoenix, North Country Community Health Center, Inc. in Flagstaff, Phoenix Day Child and Family Learning Center, Pinal County Division of Public Health in Coolidge, and Yavapai Big Brothers Big Sisters in Prescott. These organizations provide:
  - Information through employer-based activities,
  - Assistance in the application process,
  - Follow up to assure that all eligibility and enrollment processes are completed, and
  - Compilation and analysis of data for community projects (ASU).

  The grants were one time only. All grants have expired except for Yavapai Big Brothers Big Sisters in Prescott which will end March 2003. The compilation and analysis of outreach data is underway.

- St. Luke's Health Trust Initiatives

  The Kids Connect initiative is a three-year program that began in the spring of 1999. The initiative granted a total of $840,213 to Maricopa County East Valley Boys & Girls Clubs, Lake Powell Medical Center which also covers Page and Chapter Houses on the Navajo Reservation, Patagonia School Districts in Patagonia, Santa Cruz County, Phoenix Children's Hospital and Native American Community Health Center, Pima Prevention in Tucson,

Scottsdale Prevention Institute, and Valley Interfaith Project for central and western Phoenix.

With the exception of the Scottsdale Prevention Institute grant, which ends in April 2002, all other grants have ended. The compilation and analysis of outreach data is underway.

Health Plans Strategies & Activities

AHCCCS contracted health plans are also contributing to the KidsCare outreach efforts. Health Plans statewide have promoted the KidsCare Program at health fairs and community events such as block watch gatherings and cultural events. Health Plans have also supported the KidsCare outreach staff at various promotions around the state.

IHS & Tribal Entities Strategies & Activities

IHS facilities and Tribal entities statewide, have been and continue to be very diligent in screening and assisting families with the completion of KidsCare applications. They are part of the success in the substantive increase in Native American KidsCare enrollment. Examples of these varied outreach efforts are as follows:

- The number of Native American children in the KidsCare program has continued to increase at a modest but steady level, at a rate of approximately 100 children per month during calendar year 2001. The majority of these children were enrolled through the efforts of the IHS facilities. Each IHS facility is mandated to explore alternative health care resources for Native Americans. Throughout the state, the IHS facilities have contributed to the expanding enrollment for children who reside on reservations. Accordingly, most eligible families have opted to enroll their children with IHS as their health plan. KidsCare outreach staff have worked closely in Maricopa County with the HIS facility, offering training assistance as turn over in staff occur and doing reviews of policy changes as they occur.
- Tribally operated health care programs have also contributed to the enrollment of Native American children. Each tribe designed their outreach plans based on the uniqueness of their communities:
  - Organizing community health fairs and other events focusing primarily on children's health, and
  - Incorporating the application process into other tribal programs by capturing information that can also be used to complete the KidsCare application.
- Such programs as Women, Infants and Children, Head Start, and other social service and educational programs have also played an active role in assisting families enroll their children in KidsCare.
- There are other programs in the state's metropolitan areas that target the Native American community. Through a grant from St. Luke's Charitable Trust, the Native American Community Health Center and the Phoenix Children's Hospital have hired outreach and enrollment specialists to assist families in completing application forms. These programs have hired staffs of Native American heritage who are able to interact with Native American families residing in urban areas. The staff also follow up with families by:
  - Conducting home visits,
  - Assisting potential applicants with verification of income documents, and
  - Generally providing consumer education to make an informed choice regarding health plan selections.

F. Eligibility determination process

On October 1, 2000, the KidsCare program implemented a policy change that allows eligibility determinations to be made based on the income that the applicant declares on their application, as long as there are no discrepancies to that income found in the case file or in the computer systems. If a major discrepancy exists, the Eligibility Interviewer (EI) will attempt to contact the applicant to clarify the discrepancy. If the EI is unable to contact the applicant, they will then issue a

pending notice requesting verification of the discrepant income. This has not only streamlined the process; it has also greatly reduced the number of children who are denied KidsCare for failure to provide information. The average number of children who were denied for failure to provide information per month in 1999 was 867 (30.2%). In 2000 when written verification was not required the three month average went down to 673 (21.6%). The average monthly denial rate for failure to provide information for the first three months of 2001 is 303 (9.7%).

G. Eligibility redetermination process

KidsCare initially mailed a preprinted form for renewal. This form was complicated and confusing for many applicants. In December of 2000, AHCCCS started using a nonpreprinted one page renewal form. The new form is printed in English on one side and Spanish on the reverse. The requested information is limited to only those elements needed for renewal. An informational introduction sheet is included with the renewal form that explains it's purpose and what verification is needed. A self addressed stamped envelope is also enclosed to encourage return.

The new renewal form has greatly reduced the time that it takes to process a renewal because approximately 85% of the new renewal forms that are received are completely filled out with all necessary verification attached. This results in fewer of the renewal applications denied for failure to provide enough information to complete the eligibility determination. For FY 2001, 97.03% of all renewal applications received were approved.

Initially all KidsCare Eligibility Interviewers processed renewal applications. In April of 2001 the office was reorganized and a renewal unit was established. The Eligibility Interviewers in this unit process renewal applications exclusively. This helps to ensure that renewals are processed in a more timely fashion.

H. Benefit structure

As a result of legislation, beginning October 1, 2001, children enrolled in KidsCare receive the same service package as those enrolled in Medicaid. This change removed limits on vision screening and eyeglasses and on behavioral health services. It also made non-emergency medical transportation available to KidsCare recipients.

I. Cost-sharing policies

As a result of legislation, a family may avoid termination of coverage resulting from non-payment of premium by showing the existence of a hardship. Hardship is defined as medical expenses or health insurance premiums for non-KidsCare family members, repairs to the home or to vehicles used to get to work which cumulatively exceed ten percent of the family's gross household income. The death of a family member is also considered a hardship. This change becomes effective for premiums for October 2001. Results of the change will be submitted in the FFY 2002 report.

J. Crowd-out policies

Effective for eligibility beginning October 1, 2001 Arizona Statute reduced the mandatory waiting period following voluntary termination of other creditable health insurance coverage from six months to three months. Because a child may be approved up to three months prospectively if all eligibility requirements are met except for the waiting period, a major impact is that applications are no longer denied due to the waiting period. The waiting period is waived entirely for a seriously or chronically ill child. It is too early to determine the impact of this change. Results of the change will be submitted in the FFY 2002 report.

K. Delivery system

NC

L. Coordination with other programs (especially private insurance and Medicaid)

Coordination efforts are as listed:

- The Community Based Organization Partnership (CBOP) program was established on April 14, 2001. AHCCCS contracted with seven grantees throughout the state to assist in locating and assisting individuals and families in applying for all AHCCCS programs. These grantees piloted the new Universal Applications and submitted them to the CBOP application unit for screening and processing. The CBOP Unit is made up of EIs from both KidsCare and Medicaid. The six EIs screen the applications and then make the applicable eligibility determinations. This outreach effort has resulted in 611 children being approved for KidsCare from April 14, 2001 to September 30, 2001.
- Effective October 2001, AHCCCS is using the Universal Application on a statewide basis. As a result of the implementation of the Universal Application, two new units were developed to screen applications for any potential program for which an applicant may be eligible. Prior to the Universal Application, each program had its own application.
  - These applications are all sent to the Central Screening Unit (CSU). This unit is also consists of EIs from both KidsCare and Medicaid. They screen the application for potential eligibility and forward the applications to applicable programs to be processed. Results of this program will be submitted in the FFY 2002 report. **NOTE**: The CBOP outreach grantees will continue to submit Universal Applications to the CBOP Unit for processing so that their outreach efforts can be monitored.

M. Screen and enroll process

NC

N. Application

The initial application for KidsCare has experienced two transformation during this last fiscal year.

- In April of 2001 KidsCare designed and piloted a new application form. The design of the application was changed from landscape on the old form to portrait on the new form. This was a change requested by the Eligibility Interviewers (EIs) who said that this would make it easier to process cases. There are several other suggestions made by the EIs that were used in the new design. We also received suggestions from outreach staff and clients on how to make the form easier to fill out. The wording of the questions were simplified and many check boxes were added. The pilot showed that this change resulted in it taking less time for a client to complete this form as opposed to the old form. The new form also helps sell the program because on the front page it tells the potential client what they want to know about the program: What are the services, what is the cost to them, what are the income limits and how to apply for the program. KidsCare started using this form in August of 2001.

- In October of 2001 the implementation of the Universal application form began. One application is used to determine eligibility for all household members in any program that is applicable to them. Most of the changes implemented in the new KidsCare application were used when the development of the Universal application began. This application is used to determine eligibility in any of the AHCCCS medical programs. Prior to the Universal Application, each program had it's own application. If a household contained members who were eligible for several different programs, they would need to fill out a separate application for each program. This increases the efficiency and effectiveness of the application process for all programs.

- ***Redetermination:***
  See subsection "1.1-G".

O. Other

The two changes noted below have reduced the interruptions for EIs and has resulted in reducing

the time that it takes to process an initial application. From October 2000 through April 2001 the average time to process an initial application was 32.8 days. From May 2001 through September 2001 the average processing time has reduced to 22.5 days.

Unit reorganization

In April of 2001 the KidsCare office reorganized and streamlined many procedures. Prior to this date all EIs processed both intake and renewal applications, completed any changes to the case file, worked on many reports relating to cases and various other duties. After reorganization, units were assigned to work either initial applications, renewal applications or specialized functions. This has made it easier to train new EIs in one area of eligibility at a time. It has also reduced distractions and assisted them in their caseload management. There was also a change in clerical assignments. Prior to reorganization, all applications were registered by a central unit. Changes were made to assign a clerical person to each unit and established two other clerical units who have specific duties such as answering phones, working in the file room, and opening mail.

Improved Phone System

In May of 2001 the KidsCare office acquired a new phone system. This system is answered automatically and the caller is able to choose several options. This makes it possible to separate the English and Spanish calls and also has two automated call distributors that are able to send calls to the appropriate unit depending on whether the caller wanted general information or needed to report a change. This system also has an option that sends the caller to a voice mail if they are requesting an application. The voice mail prompts the caller to give demographic information needed to send the application. This allows the caller to request an application 24 hours per day and seven days / week.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

As of October 1, 2001, 53,685 children were enrolled in the KidsCare program, up from 38,073 on October 1, 2000. This information is from monthly enrollment reports generated by the KidsCare Enrollment Determination System (KEDS).

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As of October 1, 2001, 77,362 were enrolled under Medicaid as a result of having applied for KidsCare then being found eligible for Medicaid. On October 1, 2000 this figure was 44,906. This information is from monthly enrollment reports generated by KEDS.

The Kaiser Commission on Medicaid and the Uninsured in the September 2001 edition indicated that the total SCHIP enrollment for Arizona experience a the 49% growth from December 1999 to December 2000. The average rate of growth for separate SCHIP programs was 47%.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

N/A

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

_x_ No, skip to 1.3

_____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 **(1)** **Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
Decrease the percentage of children in Arizona who are uninsured or do not have a regular source of health care.	Decrease the percentage of children in Arizona who are uninsured. In the first year of the KidsCare program, decrease the percentage of children with income under 150% of FPL who are uninsured. In subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.	**Data Sources:** Current Population Survey (CPS) AHCCCS monthly enrollment figures **Methodology:** During this reporting period, AHCCCS used CPS data for the number and percent of children under 19 years of age, at or below 200 percent of FPL, based on three-year averages for 1996, 1997, and 1998. AHCCCS also used monthly enrollment figures to determine the number of children who currently have creditable coverage. • **Numerator:** Total KidsCare and Medicaid enrollment • **Denominator:** Baseline figure of 311,000. **Progress Summary:** As of October 1, 2001, AHCCCS had insured 131,047* children (Title XIX and Title XXI) in Arizona. This is an increase of 48,068 children (58%), since October 1, 2000 (See also outreach efforts, Section 1.1(E) which describes the positive impact of outreach on enrollment) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons.

Table 1.3 **(1)** **Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Increasing SCHIP Enrollment: Decrease the percentage of children in Arizona who are uninsured or do not have a regular source of health care.	Decrease the percentage of children in Arizona who are uninsured. In the first year of the KidsCare program, decrease the percentage of children with income under 150% of FPL who are uninsured. In subsequent years, decrease the number of children with income under 200% of FPL who are uninsured.	**Data Sources:** Current Population Survey AHCCCS monthly enrollment figures **Methodology:** During this reporting period, AHCCCS used CPS data for the number and percent of children under 19 years of age, at or below 200 percent of FPL, based on three-year averages for 1996, 1997, and 1998. AHCCCS also used monthly enrollment figures to determine the number of children who currently have creditable coverage. **Progress Summary:** As of October 1, 2001, 53,685 children were enrolled in the KidsCare Program. This is an increase of 15,612 children (41%), since October 1, 2000. (See also outreach efforts, Section 1.1(E) which describes the positive impact of outreach on enrollment) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons.

Table 1.3 **(1)** **Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)**	**(2)** **Performance Goals for each Strategic Objective**	**(3)** **Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Increasing Medicaid Enrollment: Coordinate with other health care programs providing services to children to ensure a seamless system of coverage.	Coordinate with other health care programs providing services to children to ensure a seamless system of coverage. Out Station KidsCare Eligibility Workers in Yuma, Flagstaff, and Pima counties to assist with outreach activities and applications and maximize coordination with other health care programs. Eligibility workers are outstationed to assist with outreach efforts. Note: During FFY 2000 AHCCCS established four Outreach Coordinators to improve and enhance outreach strategies. The coordinators have geographic areas which cover the entire state (ttachment A).	**Data Sources:** Internal KidsCare eligibility data and Medicaid enrollment data. **Methodology:** Record match between SCHIP eligibility data and Medicaid enrollment data performed. • **Numerator:** Number of children enrolled in Medicaid because of KidsCare application. • **Denominator:** Total number of children who have creditable coverage because of KidsCare application. **Progress Summary:** As of October 1, 2001, approximately 77,362 children were transferred from KidsCare to Title XIX or KidsCare was denied and Title XIX was approved. This is an increase of 32,456 children (72%), since October 1, 2000. (See Attachment A,A-1, A-2, A-3 B, C and D for further detail.) (See also outreach efforts, Section 1.1(E) which describes the positive impact of outreach on enrollment) **Note:** *This is a current monthly figure. It does not represent the total number of children approved. Each month children leave the program for various reasons. KidsCare and Title XIX have coordinated efforts to ensure a smooth eligibility determination process: • DES staff have been trained to process dual applications. • AHCCCS and DES meet weekly regarding KidsCare and Medicaid activity. • Manuals have been written for the dual eligibility process.

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
1. Decrease the percentage of children in Arizona who are uninsured or do not have a regular source of health care 2. Decrease the percentage of children who do not have a regular source of health care.	A key indicator of whether children and adolescents have a regular source of health care is whether services, particularly primary care and preventive services, are being used throughout the course of a year.	**Data Sources:** AHCCCS claims and encounters system AHCCCS recipient records **Methodology:** Using methodology published by the National Committee for Quality Assurance (NCQA) as part of the Health Plan Employer Data and Information Set (HEDIS®), AHCCCS measured the number of KidsCare children under 19 years of age who were continuously enrolled with one acute-care health plan during the contract year ending September 30, 2000, and who had at least one visit to a Primary Care Practitioner (PCP). The rate was calculated as a percent of KidsCare members who met the continuous enrollment criteria. Primary Care Practitioners include general or family practice physicians, internal medicine physicians, obstetricians and gynecologists, pediatricians, physician assistants, and nurse practitioners. **Progress Summary:** • The overall rate of access to PCPs by AHCCCS members eligible through KidsCare increased by 3 percentage points from the previous contract year. During the reporting period, 62.9 percent of KidsCare members had a PCP visit**,** compared with the previous year's rate of 59.9 percent. • Rates for KidsCare members ages 1 through 6 are comparable to the most recent (calendar year 1999) national averages for Medicaid health plans, as reported by NCQA. The rate for KidsCare members who were 1 year old was 86.4 percent, compared with the Medicaid national average of 84.4 percent. The rate for KidsCare members 2 through 6 years old was 71.5 percent, compared with the Medicaid national average of 73.8 percent.

2. Ensure that KidsCare-enrolled children in Arizona have access to a regular source of care.	AHCCCS has established a goal for the contract year ending September 30, 2000, that 70 percent of members younger than 21 years of age (i.e., Title XIX **and** Title XXI recipients) have access to primary care practitioners as indicated by at least one PCP visit during the contract year.	**Data Sources:** AHCCCS claims and encounters system AHCCCS recipient records **Methodology:** Using methodology published by the National Committee for Quality Assurance (NCQA) as part of the Health Plan Employer Data and Information Set (HEDIS®), AHCCCS measured the number of KidsCare children under 19 years of age who were continuously enrolled with one acute-care health plan during the contract year ending September 30, 2000, and who had at least one visit to a Primary Care Practitioner (PCP). The rate was calculated as a percent of KidsCare members who met the continuous enrollment criteria. Primary Care Practitioners include general or family practice physicians, internal medicine physicians, obstetricians and gynecologists, pediatricians, physician assistants, and nurse practitioners. **Progress Summary:** • The overall rate of access to PCPs by AHCCCS members eligible through KidsCare increased by 3 percentage points from the previous contract year. During the reporting period, 62.9 percent of KidsCare members had a PCP visit**,** compared with the previous year's rate of 59.9 percent. • Rates for KidsCare members ages 1 through 6 are comparable to the most recent (calendar year 1999) national averages for Medicaid health plans, as reported by NCQA. The rate for KidsCare members who were 1 year old was 86.4 percent, compared with the Medicaid national average of 84.4 percent. The rate for KidsCare members 2 through 6 years old was 71.5 percent, compared with the Medicaid national average of 73.8 percent.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
• Improve the health status of KidsCare members through a focus on early preventive and primary care. • Improve the percentage of KidsCare-eligible children who receive preventive and primary care by meeting the following goals for all AHCCCS members under 21 years of age (Title XIX **and** Title XXI recipients) for the contract year ending September 30, 2000.	Improve the percentage of KidsCare-eligible children who receive preventive and primary care by meeting the following goals for all AHCCCS members under 21 years of age (Title XIX **and** Title XXI recipients) for the contract year ending September 30, 2000: • 82 percent of children two years old will have received all doses of three vaccines, including Diphtheria, Tetanus, acellular Pertussis (DTaP); Inactivated Polio vaccine (IPV); and Measles, Mumps, Rubella (MMR). • 64 percent of children 15 months old will have had at least six well-child visits • 64 percent of children 3 through 6 years old will have had an annual well-child visit • 55 percent of children 3 through 20 years old will have had an annual dental visit	**Data Sources:** AHCCCS claims and encounters system AHCCCS recipient records **Methodology:** Immunizations for AHCCCS members who turned 2 years old during the contract year ending September 30, 2000, were measured through a medical chart audit conducted by an external quality review organization (EQRO). Members included in the study were continuously enrolled with one acute health plan during the contract year. Results were reported separately for Title XIX-eligible and Title XXI-eligible (KidsCare) members. Using methodology published by the National Committee for Quality Assurance (NCQA) as part of the Health Plan Employer Data and Information Set (HEDIS®), AHCCCS also measured the percent of children and adolescents who had well-care visits and dental services and who were continuously enrolled with one acute-care health plan during the contract year ending September 30, 2000. Services are based on claims and encounters submitted by acute health plans. Service utilization rates include both Title XIX and Title XXI recipients, as specified in the KidsCare State Plan Amendment #99-03. **Progress Summary:** • For the contract year ending September 30, 2000, the combined three-antigen immunization rate for KidsCare members was 78.5 percent, compared with a rate of 77.5 percent for Medicaid-eligible (Title XIX) enrollees. (The 1999/2000 contract year marks the first year that immunization rates for KidsCare members were measured separately from Title XIX members.) • For the contract year ending September 30, 2000, the proportion of 15-month-olds (including both KidsCare and Title XIX-eligible members) who had at least six well-child visits improved for the third consecutive year. The AHCCCS overall ratio for this indicator was 58.3 percent, an increase over the previous year's rate of 55.2 percent. • For the contract year ending September 30, 2000, the overall rate of children 3 through 6 years old (including both KidsCare and Title XIX-eligible members) who had an annual well-child visit was virtually unchanged from the previous year. In the current reporting period, 44.5 percent of children had an annual well-child visit, compared with the previous year's ratio of 44.4 percent. • For the contract year ending September 30, 2000, the overall proportion of 3 through 20 year-olds (including both KidsCare and Title XIX-eligible members) who had at least one annual dental visit during the reporting year was 43.5 percent, an increase from the previous year's rate of 42.6 percent.

Other Objectives		
1. Increase the access to interpreter services for members with limited English proficiency (LEP)	A member survey conducted by AHCCCS in 1996 suggested that their was a lower satisfaction for members with LEP and that their inability to communicate with providers was a contributing factor. AHCCCS has taken steps to increase access to interpreters for these members with the expectation that satisfaction with care will increase.	**Data Sources:** AHCCCS has used member surveys to gauge satisfaction with members. Health plan audits have been used to assess the degree to which the health plan has made interpreters available. **Methodology:** The CAHPS member survey AHCCCS used in 2000 included questions about access to interpreters and difficulty in communicating with providers. **Progress Summary:** The 2000 member survey indicated that this was a continuing issue. However, the survey was conducted before the affects of AHCCCS's cultural competency initiative and Cultural Competency Policy could be measured. Audits of health plans have indicated that members are made aware of interpreter services and that these services are made available as needed. AHCCCS has recently provided the health plans with data indicating member language preferences which should help health plans to direct needed interpretation services.
2. Increase the quality of care as measured by members' perceptions.	A goal of exceeding nationwide averages of how members rate their health plan was set for this year because it was the first time AHCCCS has done a member satisfaction survey that included KidsCare.	**Data Sources:** AHCCCS used a CAHPS member survey and National CAHPS Benchmarking database for comparison to national averages. **Methodology:** AHCCCS extracted the results of KidsCare members that responded to its CAHPS member survey and compared that to the national averages for Medicaid health plans. NCBD, as of this past year, did not offer Title XXI comparisons, so Title XIX was the best available and AHCCCS's Title XIX and XXI programs are almost identical. **Progress Summary:** AHCCCS was able to make this comparison and found that satisfaction with AHCCCS health plans was substantially higher than with the average Medicaid and/or commercial health plan. See attached chart.

3. Avoid "crowd-out" of employer coverage.	Screen 100 percent of applications to determine if the child was covered by an employer sponsored insurance within the last three months.	**Data Sources:** Enrollment application **Methodology:** 1. Application will screen family on previous coverage. 2. The Administration will monitor percent of total denials due to applicant having group or other health insurance and the delay in enrolling a child pending expiration of a six month bare period. Beginning October 1, 2001 the six month bare period was reduced to three months • **Numerator:** Number of applications screened for crowd-out and number actually denied for this reason. • **Denominator:** Number of applications. **Progress Summary:** From the implementation of the KidsCare program until September 30, 2001, 3834 children or 3.64 percent of the total denials have been because the applicant was covered by group or other insurance. This figure does not include those children who were denied because they already had Title XIX coverage. AHCCCS does not enroll children until at least three months have passed since voluntary termination of other health insurance illness the child is seriously or chronically ill.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Over the past several years, AHCCCS health plans have implemented a variety of interventions designed to improve access to services by children and adolescents (both Title XIX- and Title XXI-eligible members). These activities include monitoring services for individual children through claims and copies of AHCCCS tracking forms used by providers, and sending reminders to parents to take their children for immunizations, well-child exams and dental visits. Other actions include notifying PCPs of their assigned members who are overdue for preventive services, offering incentives for children to complete their annual exams or immunizations, and providing targeted education to PCPs with lower rates of compliance. Continued education about the importance of preventive health care for children through member materials and other avenues, such as partnering with community outreach programs to get these messages to hard-to-reach families, also may help improve access to health care for these members.

While the current programs have had some beneficial effect, challenges to meeting benchmark goals continue to exist. A study by the Florida Medicaid agency found that the top three reasons given for missing pediatric appointments were: not having transportation to the appointment, the child no longer was sick, and forgetting about the appointment.[1] Many families whose children qualify under SCHIP have never had health insurance because they could not obtain it through an employer and had incomes too high to qualify for Medicaid. Prior to the contract year that started October 1, 2001, families had to have been without health insurance for six months prior to initiation of coverage in order to be eligible for KidsCare. These families, who traditionally relied on hospital Emergency Departments as their primary source of care, may have difficulty understanding the health care system and how to access preventive services through managed care plans.[2]

AHCCCS will continue working with health plans to improve access to care among KidsCare members and ultimately move Arizona closer to meeting Healthy People 2010 goals. Health plans that do not meet contractual expectations may be required by AHCCCS to submit corrective action plans. But, like all interventions aimed at increasing access to health services, improvement strategies will take considerable time and resources to effect demonstrable improvement.

[1] U. S. General Accounting Office: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services; July 2001

[2] National Center for Education in Maternal and Child Health: Successful Outreach Strategies: Ten Programs that Link Children to Health Services; January 1999

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

In addition to the four performance goals related to utilization of specific services mentioned above, AHCCCS also has set a goal for adolescent access to preventive services. For the contract year ending September 30, 2000, the AHCCCS overall goal was that 45 percent of members ages 11 through 20 (including Title XIX and Title XXI recipients) would have had a well-care visit in the past 24 months. Data for the 1999/2000 contract year is not yet available, but the overall rate for the previous contract year was 47.9 percent.

Also as mentioned in the previous section, AHCCCS has begun reporting immunization rates for children enrolled in acute care health plans through KidsCare separately from Title XIX members. These results were first reported in the AHCCCS Annual Immunization Assessment of Two-year-old Members, which was completed in the Spring of 2001 and submitted to CMS in May.

To improve the use of dental services among all children and adolescents served by AHCCCS, the agency and its contracted health plans have convened an oral health work group in partnership with the Arizona Office of Oral Health (OOH). This group is exploring new strategies that may be implemented on a broader, collaborative basis and thus may have a greater effect on encouraging use of dental services.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

N/A

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

ATTACHMENT A, A-1, A-2, and A-3: OUTREACH MAPS

- Counties Targeted for Kids Outreach by AHCCCS Employees
- Counties Targeted for KidsCare Outreach by Foundations
- Counties Targeted for KidsCare Outreach by Community Based Organizations
- IHS Facilities and Other Entities that Target the KidsCare Population

ATTACHMENT B: APPLICATIONS

- Total Kids Enrolled for Health Care Coverage Due to KidsCare
- Number of Applications

ATTACHMENT C: KIDSCARE IMPACT

- KidsCare and Transfers To Title XIX

ATTACHMENT D: CONTRIBUTING FACTORS TO MEDICAID GROWTH

- Additional information on increase in the Medicaid Population

ATTACHMENT E: KIDSCARE CONSUMER INFORMATION

- Flyer

ATTACHMENT F1 and F2: STATE BY STATE SCHIP ENROLLMENT COMPARISON

- Kaiser Commission: Enrollment in State CHIP Programs: December 1998 to December 2000 (Charts)

ATTACHMENT H: DEMOGRAPHICS

- Ethnicity
- Age

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Not Applicable

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

0 Number of adults

0 Number of children

C. How do you monitor cost-effectiveness of family coverage?

Not Applicable

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Not Applicable

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

0 Number of adults

0 Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

KidsCare staff screen for other health insurance indicated on the application form. The crowd-out provision for KidsCare states that a child may not have creditable health insurance coverage and may not have had it for a period of three months (until October 1, 2001, six months) prior to enrollment in the KidsCare Program, unless the termination was involuntary or the child is seriously or chronically ill.

B. How do you monitor and measure whether crowd-out is occurring?

This information is provided via a monthly denial report indicating reason for denial. Until August 1, 2001, if a child had more than three months remained before their period of ineligibility ended, the child's application would have been denied. If three months or less remained before their period of ineligibility ended, AHCCCS pended the case for review and reprocessing after the period of ineligibility. Beginning August 1,2001, if the child is otherwise eligible, coverage is approved, to begin after the end of the period of ineligibility.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

From the implementation of the KidsCare program until September 30, 2001, 3834 children or 3.64 percent of the total denials have been because the applicant was covered by group or other insurance. This figure does not include those children who were denied because they already had Title XIX coverage.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

See responses to number 2 and number 3, above.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

AHCCCS has found that a combination of several activities is the best way in reaching this population.

- The utilization of media to support special sign up events has been proven to be very effective. AHCCCS has also found that media, specifically the use of radio and television ads, has proven to be very effective.
- Smaller and rural communities respond best to the use of lay health workers or community representatives. Special events are also a draw in rural Arizona. For example swap meets are productive. Partnering with the coalition members for one swap meet event yielded 86 applications. These efforts can be measured by the number of applications completed at the events along with the number of phone call our KidsCare hotline receives.
- The utilization of community based outreach workers has also proven to be very successful. AHCCCS chose to utilize community based organizations as they:
  - Know how to find and engage people requires local knowledge;
  - Have the ability to design and implement outreach strategies at the local level;
  - Know of who in the community needs health care; and
  - Offer customized outreach and trusting relationships.

  AHCCCS can track the number of applications the seven community based organizations have submitted along with the number of children determined eligible for KidsCare through their outreach efforts.
- AHCCCS and the Department of Education (DOE) recently partnered to notify families of the KidsCare program through the Child Nutrition Program.
  - AHCCCS printed and sent one million flyers to 381 school districts that participated the Child Nutrition Program.
  - Families completed the simple form, answering three self-screening questions and returned it to the school if their child was uninsured, and they wanted an application mailed to them.
  - To date, AHCCCS has received and responded to 18,274 requests for applications from 86 school districts.
- Hospitals have partnered with AHCCCS in a project to reach the "treat and release" emergency and urgent care patients. Hospitals have trained clerical staff to offer the KidsCare flyer to families with uninsured children. This form is then forwarded to an AHCCCS coordinator who contacts the family and provides application assistance. This process has proven successful for hospitals to receive

reimbusement if the child is Medicaid or KdsCare eligible AHCCCS has provided signage and developed the form used to screen patients who may be eligible. To date over 204 forms have been obtained, resulting in 86 applications. Further data will be available in the 2002 report.

- AHCCCS has been partnering with small businesses. To date, AHCCCS staff has contacted over 400 businesses. Results thus far have produced requests for 187 applications. Further data will be provided on this process in the report for 2002.
- Immunization events are a productive venue to reach families. There are many of them conducted around the state. It is not always possible to have an outreach person at these events so AHCCCS has been researching the use of a self screening flyer which would be made available at these events. Data on this process will be provided in the 2002 report.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Hispanic population

- The majority of the participants at the swap meets were Hispanic: This was an excellent method of reaching the Hispanic community.
- AHCCCS has worked closely with the Arizona Interagency Farm worker Coalition (AIFC). Packet of information with eligibility criteria in English and Spanish were given and assistance with training was offered.

Native American

AHCCCS has trained over 40 Native American medical staff members regarding the KidsCare application, processes, and procedures. The explanation of services and why this benefits Native Americans has contributed to their increased participation in KidsCare.

See also "A" and "C" of this subsection

C. Which methods best reached which populations? How have you measured effectiveness?

To date, AHCCCS has found the following trends:

- Personal contact with members at scheduled events has produced the best results. Radio advertising for an event and having radio personalities present at an event helps to reach the Hispanic population. The number of application taken and number of children included on the application is one way to measure the effectiveness of the events.
- The effectiveness of the events can also be measured by the increase in networking. Community contacts with other agencies, community activists, school nurses, and business people who become knowledgeable about the program and promote it in their communities or become actively involved in obtaining applications have to be considered when measuring effectiveness.
- Through a grant from the Flinn Foundation, Arizona State University (ASU) is currently compiling the outreach program data for Children's Action Alliance, St. Luke's Charitable trust, and the Flinn Foundation. The summary report is expected at the end of the three-year projects (2002) The research results will also identify those strategies which were most successful and should be replicated.

See also "A" and "B" of this subsection

2.5 Retention:

A. What steps is your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

AHCCCS is using several strategies to accomplish this goal:

- In December of 2000, AHCCCS started using a nonpreprinted one page renewal form. The new form is printed in English on one side and Spanish on the reverse. The requested information is limited to only those elements needed for renewal.. An informational introduction sheet is included with the renewal form that explains it's purpose and what verification is needed. A self addressed stamped envelope is also enclosed to encourage return.
- The new renewal form has greatly reduced the time that it takes to process a renewal because approximately 85% of the new renewal forms that are received are completely filled out with all necessary verification attached. This results in fewer of the renewal applications denied for failure to provide enough information to complete the eligibility determination. For FY 2001, 97.03% of all renewal applications received were approved.
- When a child loses Medicaid due to excess income and is eligible for KidsCare, the child is systematically approved for KidsCare with no break in coverage. If there is a discrepancy, that must be cleared prior to the child being approved for KidsCare, the system generates a report that is reviewed and processed by a KidsCare EI.
- AHCCCS has contracted with Community Based Organizations to follow up with families that do not submit their renewal form.
- AHCCCS is planning to develop a survey form to send to members when they are disenrolled from the program to attempt to identify barriers so that AHCCCS staff can attempt to eliminate those barriers, wherever possible.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

☒ **Follow-up by caseworkers/outreach workers**
Prior to discontinuing the case, the KidsCare EI attempts to call the member and offer assistance with the renewal process.

☒ **Renewal reminder notices to all families**
A renewal reminder notice is sent to all members 20 days after the renewal form is sent.

☒ **Targeted mailing to selected populations, specify population**
AHCCCS is exploring the possibility of mailing out postcards on a quarterly basis. This will help to educate members about such things as immunizations and well child care visits. It can also assist as reminders to report such things as address changes.

☒ **Information campaigns**
Public forums are conducted twice a year by the Public Information Officer and Community Relations Manager to inform communities about all AHCCCS programs. The KidsCare and Medicaid programs are explained at these forums.

☒ **Simplification of re-enrollment process, please describe**
A special procedure has been implemented for members who have been discontinued for nonpayment of premiums. If the back premiums are paid by the 25th of the month the discontinuance was effective (e.g., member discontinued effective 1/1/01 and pays premiums 1/24/01), the member is re-enrolled effective

the first day of the next prospective month (2/1/01) without requiring a reapplication.

☒ **Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe**
Arizona participated in a SWAT team sponsored by NASHP along with five other states. This group conducted a survey to attempt to determine why families disenroll in the SCHIP program. The survey has been completed, however we do not yet have the results. This information will be submitted in the FFY 2002 report.

☐ **Other, please explain**
N/A

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.
NC

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?
If the renewal application is not returned, the Eligibility Interviewer attempts to contact the family via telephone to get them to complete and return the form. They will also complete the application over the telephone and mail it to the member for a signature if requested.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.
Arizona is participating in the SWAT Team sponsored by NASHP to collect disenrollment and reenrollment data.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The KidsCare application is a joint SCHIP and Medicaid application. The renewal form is also accepted by Medicaid as an application for the children. KidsCare started accepting member declaration for income verification in October 2000. Medicaid always requires verification of income. If the children can be approved for KidsCare using the member's declared income, and the case screens eligible for Medicaid, the children are approved for KidsCare. A notice is then mailed to the member explaining why additional information is needed. Whenever possible, the KidsCare EI will attempt to contact the employer and collect the information for Medicaid. If Medicaid is subsequently approved, it overrides the KidsCare coverage.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

A unique partnership has been established between the KidsCare program and the Department of Economic Security (DES) who presently determines the Medicaid eligibility for families and children. KidsCare cases that screen potentially eligible are then referred to a special DES unit that processes all medical emergency cases referred to them within 24 hours. Other potentially eligible cases are also sent to this DES unit where they are screened and sent from this unit to the appropriate DES office for determination.

Whenever children loses their Medicaid eligibility because of excess income, a systematic referral is made to KidsCare. If the child is eligible for KidsCare the computer automatically opens a case and approves the child for KidsCare.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

The same health plans are available to Medicaid and KidsCare enrollees.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

AHCCCS is currently in the process of developing a member satisfaction survey in which we ask a question about how the individual member is impacted by the KidsCare premium. In October of 2001 KidsCare policy changes to allow KidsCare to waive the premium at time of disenrollment for a member who is undergoing certain personal hardships. Data received will be submitted in the FFY 2002 report.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

N

No.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

Information is available from the following sources:

- Health Plan Employer Data and Information Set (HEDIS®) measures of access/availability of care and use of services); these service indicators are used to

evaluate health plan-specific performance

- Contractor oversight (including on-site reviews, annual and quarterly progress reports, and corrective action plans, if necessary)
- State-specific performance measure (Annual Assessment of the Immunization Status of Two-year-olds); this measure also is used to evaluate health plan-specific performance
- EPSDT Tracking Forms
- Member grievance process/quality of care issues

A primary component of quality is access to care and utilization of services. As discussed in Subsection 1.3, Performance Goals, AHCCCS has specific measures of access to care, based on HEDIS® methodology. In some cases, AHCCCS evaluates utilization of services by KidsCare in combination with the Title XIX population. Immunization of Two-year-olds and Access to PCPs is evaluated separately for the KidsCare population. Results of these service indicators are discussed in Subsection 1.3.

In addition, AHCCCS monitors the provision of services to all children and adolescents through on-site reviews of each health plan. AHCCCS Clinical Quality Management staff review policies and procedures, quality of care issues, utilization reports, service denial reports and care coordination processes.

In cooperation with health plans and pediatric providers, AHCCCS, designed EPSDT Tracking Forms several years ago that have been cited nationally as a "best practice." These forms help guide physicians in providing all the necessary components of a well-child visit at any given time in the child's life, as well as ensuring that referrals are made when necessary. A copy of the tracking form, which is completed for each well-child visit, is maintained in the child's medical record and a copy is sent to the child's health plan. This allows the health plan to concurrently track whether children are receiving all the necessary services at the appropriate intervals. Information from tracking forms is entered by each health plan into a database.

The 2000 AHCCCS Member Survey provides an insight to the quality of care as seen from the members' perspective. The results are encouraging, as AHCCCS members rated their health plans, ability to get needed care, personal doctor and specialist above national averages.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

The Performance Goals previously discussed monitor access to well-baby care, immunizations and dental services.

In addition, AHCCCS monitors the provision of services to all children and adolescents through on-site reviews of each health plan. AHCCCS Clinical Quality Management (CQM) staff review policies and procedures, quality of care issues, utilization reports, service denials and care coordination processes. This monitoring is accomplished through document review and interviews with health plan staff.

Health plan activities and progress in providing Early and Periodic Screening, Diagnosis

and Treatment (EPSDT) services to all children are monitored through annual and quarterly progress reports from each health plan. These reports summarize progress toward measurable objectives for each performance indicator (e.g., percent of 15-month olds receiving all well-child visits), and describe member outreach and provider education/monitoring activities. As mentioned above, services are also monitored through the use of AHCCCS-required EPSDT Tracking Forms.

Behavioral health services to SCHIP enrolees are provided by the same delivery system as TXIX. Therefore, all of the required quality management and utilization management requirements (showing reports, member satisfaction surveys, case file reviews, quarterly quality mangement reports, medical care evaluation studies, etc.) which pertain to TXIX are, by contract, extended to the SCHIP enrollees.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

With the contract year beginning October 1, 2001, AHCCCS required acute health plans to implement Quality Improvement Systems for Managed Care (QISMC). As part of QISMC, health plans must make a "best effort" to conduct health assessments for all new enrollees (including those eligible under KidsCare). This information is being used by health plans to determine case management and care coordination needs, as well as monitor medical services provided to those members. Results of new member health assessment surveys are not scheduled to be reported to AHCCCS. However, quality management staff will monitor health plan implementation of this assessment process during on-site reviews.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. **Eligibility**

There are two primary barriers:

- The first deals with the public charge issue. AHCCCS has worked extensively with community organizations to publicize that enrollment in KidsCare does not affect citizenship applications and that AHCCCS does not report information to the Immigration and Naturalization Service.
- The crowd-out provision, requiring three months ineligibility after the insurance is dropped, is another potential barrier.

B. Outreach

Section 1.1.5, section 2.4 "Outreach," as well as section 2.5 #1-4 of this document demonstrate the outreach efforts and innovation that is currently and continuously occurring in Arizona.

Examples of successes other than those cited above:

- Outstationing the Regional Outreach Coordinators to work in their local communities has been effective.
- Collaborations have been established with many groups including the following:: City of Phoenix, AARP (to inform grandparents of KidsCare); Arizona Ecumenical Council; Mexican Consulate; Asian American Coalition; African American Coalition; border health groups; Arizona Interagency Farmworker coalition, HUD; Social Security; Az. Department of Insurance, Department of Education.
- Collateral materials have been developed specifically for KidsCare. This include brochures, posters, and flyers.
- Media products produced and distributed throughout the State: Paid public service announcements; billboards; press releases have also been effective.
- Training of providers so that they are more informed of the program and the services that are provided.

Once children are enrolled, AHCCCS its contracted health plans and program contractors have created several avenues to reach out to members and help ensure access to health care services.

- Contractors use a variety of mechanisms to communicate information about and facilitate the delivery of services, including: member handbooks, member newsletters, reminder postcards to members' parents, telephone calls and, if necessary, home visits. Lists of members due/overdue for visits/services also are sent to members' Primary Care

Providers (PCPs). Health plans participate in community health fairs and make available information about their services. They also network with community organizations such as Women, Infants and Children (WIC) offices, Head Start programs, perinatal outreach programs and churches.

- AHCCCS Administration also distributes information about EPSDT services to families with children younger than 21 years when they apply for AHCCCS. AHCCCS mails EPSDT brochures to families of members not enrolled in managed care plans (primarily children receiving services through Indian Health Services facilities) on an annual basis.
- Many contracted health plans have begun assisting parents with first time appointments. Using the AHCCCS EPSDT Periodicity Schedule, health plans send postcard reminders or letters to parents of children who are due for periodic exams. If a visit does not occur (by proof of claims data or encounter submission), then a second reminder usually is sent. Health plans have various processes for following up on children who still do not have an exam. One plan refers the case to a Coordination of Care Committee, which utilizes a multidisciplinary approach to develop a plan of care with specific goals. Another health plan's EPSDT/Immunization Coordinator will send reminder postcards, call if there is no response to the postcard, and/or visit the member's home in order to assist with getting the member into care.
- One health plan has developed a "Reach Out To Children Program (ROTC)" program that identifies, on a quarterly basis, members who have not had a dental visit in the last year. Participating dentists receive a copy of the list of those members residing within their service area. The dentist's office can then contact the member directly to schedule an appointment. Dental reminder post cards are sent to the member as well.
- Another unique process this same health plan created was to host a "Well Child Express Day," where providers are available for parents to bring their children in for screenings on a Saturday, in order to make access to care more convenient. The health plan works with a doctor's office or clinic to provide the services. It then coordinates a fun, health-fair event and publicizes it to its members in the area.
- Several health plans have developed incentive programs to encourage members to get well-child visits, dental exams or immunizations. Upon receiving proof of completing the visit from their providers, health plans will send families gift certificates for groceries or general merchandise and also may enter them in a drawing for a quarterly prize giveaway.

All of these processes are used to encourage the use of services by KidsCare members, as well as children who are enrolled in AHCCCS under other eligibility categories.

C. Enrollment

From December 1998 through December 2000 KidsCare enrollment increased from 27,765 to 41,501, or 49%, exceeding the national average of 33% for SCHIP separate program states and ranking third among states that had separate programs in place by December 1998. (Kaiser Commission on Medicaid and the Uninsured, *Chip program Enrollment, December 2000)*

D. Retention/disenrollment

During the two years since the income limit was raised from 150% to 200% of the Federal Poverty Guidelines and premiums have been charged, 8,140 children's KidsCare coverage has been stopped due to failure to pay premiums. Beginning with the premium for October 2001, children will not be discontinued for non-payment if there is a hardship in the family.

Hardship is defined as medical expenses or health insurance premiums for non-KidsCare family members, repairs to the home or to vehicles used to get to work which cumulatively exceed ten percent of the family's gross household income. The death of a family member is also considered a hardship. Because it is so recently implemented the results of this strategy are not known.

E. Benefit structure

Until October 1, 2001 KidsCare program covered services were not the same as Medicaid. There were three differences: KidsCare had limits (30-day in-patient and 30 day outpatient) on behavioral health services, did not provide non-emergency transportation, and limited vision care to one eye exam and one pair of glasses per year. These differences were eliminated effective October 1, 2001 as a result of legislation.

F. Cost-sharing

Beginning with premiums owed for the month of October 2001, families for who the premium creates a financial hardship will be able to request that the requirement to discontinue coverage for non-payment be waived. Hardship is considered when the family has medical bills or health insurance premiums for non-covered family members, or home or specified auto repairs that combined exceed 10% of the household income. The death of a household member is also a hardship. The impact of this change is not yet known.

G. Delivery system

AHCCCS has seen substantial growth in its Title XXI as well as its Title XIX populations. This has created the need to ensure the stability of the current networks and to grow these networks. AHCCCS has made this a part of its strategic plans and is working with health plans in workgroups to promote the adequacy of the network.

AHCCCS, in partnership with its contracted health plans and program contractors, strives to decrease the barriers members may experience in receiving services, especially preventive care for children and adolescents.

- High levels of immunization of young children in the state are the result of joint efforts of AHCCCS, its contracted health plans and their providers, the Arizona Department of Health Services, and community organizations participating in The Arizona Partnership for Immunization (TAPI). Children may receive immunizations through different providers (private physician offices or county health department clinics) or in different venues (e.g., at health fairs); yet the state has a coordinated system for monitoring the provision of vaccines through its automated immunization registry. Approximately 40 percent of records contained in the Arizona Statewide Immunization Information System (ASIIS) are AHCCCS members, including those enrolled through KidsCare. AHCCCS and several health plans have acquired the capability to use this database to evaluate the immunization status of members. During the past year, AHCCCS installed software and trained several staff in the Office of Medical Management to use this database.
- A common barrier to ensuring that children receive medical services is the fact that their families may not have adequate transportation. Contractors provide transportation to medically necessary services. Despite health plans' attempts to educate members, many families seem to be unaware of transportation services or do not use them appropriately. This has recently been identified as an area requiring improved member education.
- Provider capacity for some services, particularly dental, is limited in some areas of the

state. Arizona does not have enough dentists to serve its growing population and AHCCCS health plans often have difficulty contracting with an adequate number of providers, particularly in rural areas. A statewide coalition with AHCCCS, health plans, dental providers and others, which is funded by St. Luke's Health Initiatives, has been formed to address this problem and some progress in being made to recruit dentists to outlying communities.

Despite these challenges, AHCCCS and its health plan partners have improved the percentage of children and adolescents who receive preventive and primary care, as evidenced by Performance goals discussed in Section 1.

H. Coordination with other programs

Highlights of AHCCCS efforts are as follows:

- The AHCCCS relationship with the Department of Economic Security (DES) Medicaid program provides an efficient referral process.
- KidsCare brochures are included in all envelopes mailed by Vital Statistics related to requests for birth certificates. Vital Statistics also have signs with KidsCare information posted in their lobby.
- KidsCare has also been working with the Arizona Department of Juvenile Corrections (ADJC) to submit applications on incarcerated juveniles during their release processing so that medical and behavioral health services are available the day they leave the juvenile facility.
- KidsCare staff have provided training, brochures, fliers and applications to the Child Care Administration. Since their income threshold is 185%, we believe that most of their clients will qualify for KidsCare.
- KidsCare employees copy applications sent to the Premium Sharing program (state funded program) on a daily basis. Premium Sharing receives applications for medical assistance; are screened for possible KidsCare eligibility prior to being processed for Premium Sharing.

I. Crowd-out

Beginning October 1, 2001 the mandatory waiting period after voluntary cancellation of health insurance was reduced to three months from six. The three-month wait was waived for children with serious or chronic illnesses. The impact of this change is not yet known.

J. Other

Data collection for evaluation of services provided under SCHIP, as well as those provided to members in other eligibility categories, continues to be a challenge. As a managed care Medicaid program, collecting encounter data to evaluate utilization of services is difficult. Because providers are paid on a capitated basis, with most well-child services covered under this method of reimbursement, they are not well motivated to submit all encounters. AHCCCS and its contracted health plans are working on ways to overcome this barrier. Contractors are focusing on better provider education about EPSDT standards and requirements, coding seminars specific to an area of concern for provider office staff, and closer monitoring of encounter reporting.

In addition, AHCCCS has explored ways to streamline data collection. One example of this

effort is utilizing information from Arizona's statewide immunization registry, as previously noted. By using this database, contractors spend less time and resources collecting immunization records from physician offices.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.
Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2003 projected budget. Please describe in narrative any details of your planned use of funds.

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
BENEFIT COSTS			
Insurance payments			
Managed care	$ 55,680,632	$ 79,594,857	$ 105,716,574
per member/per month rate X # of eligibles	91.07		
Fee for Service	2,034,625	2,829,539	3,720,071
Total Benefit Costs	57,715,257	82,424,396	109,436,645
(Offsetting beneficiary cost sharing payments)	(1,337,710)	(1,481,794)	(1,739,174)
Net Benefit Costs	56,377,547	80,942,602	107,697,471
ADMINISTRATION COSTS			
Personnel	4,843,205	6,046,150	6,291,100
General administration			
Contractors/Brokers (e.g., enrollment contractors)	158,113	204,900	210,900
Claims Processing			
Outreach/marketing costs	465,830		
Other	1,597,730	2,603,425	2,700,100
Total Administration Costs	7,064,878	8,854,475	9,202,100
10% Administrative Cost Ceiling	6,730,002	8,993,622	11,966,386
Federal Share (multiplied by enhanced FMAP rate)	47,987,128	67,892,856	92,236,901
State Share	15,120,421	22,043,368	27,426,956
TOTAL PROGRAM COSTS	$ 63,107,549	$ 89,936,224	$ 119,663,857

4.2 Please identify the total State expenditures for family coverage during the Federal fiscal year 2001.

N/A

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2001?

___ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
_X_ Other (specify) Allocation from the Tobacco Tax Fund

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

AHCCCS does not anticipate changes at this time.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 **To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information**. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		KidsCare
Provides presumptive eligibility for children	No ☐ Yes, for whom and how long?	**x** No Yes,
Provides retroactive eligibility	☐ No ☐ Yes, for whom and how long?	☑ No ☐ Yes, for whom and how long?
Makes eligibility determination	☐ State Medicaid eligibility staff ☐ Contractor ☐ Community-based organizations ☐ Insurance agents ☐ MCO staff ☐ Other *(specify)*	☐ State Medicaid eligibility staff ☐ Contractor ☐ Community-based organizations ☐ Insurance agents ☐ MCO staff ☑ Other *(specify)* KidsCare staff employed by AHCCCS
Average length of stay on program	Specify months	Specify months Information not available
Has joint application for Medicaid and SCHIP	☐ No ☐ Yes	☐ No ☑ Yes
Has a mail-in application	☐ No ☐ Yes	☐ No ☑ Yes
Can apply for program over phone	☐ No ☐ Yes	☐ No ☑ Yes
Can apply for program over internet	☐ No ☐ Yes	☑ No Application form is available for download, but must be printed then filled in and mailed. ☐ Yes
Requires face-to-face interview during initial application	☐ No ☐ Yes	☑ No ☐ Yes

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Requires child to be uninsured for a minimum amount of time prior to enrollment	☐ No ☐ Yes, specify number of months What exemptions do you provide?	☐ No ☑ Yes, specify number of months **3** What exemptions do you provide? Exemptions are provided when the loss of insurance was involuntary (not caused by action or inaction of the child's custodial parent or guardian) *e.g.,* loss of job, death, child aged out of insurance. Children who are seriously or chronically ill are also exempt.
Provides period of continuous coverage regardless of income changes	☐ No ☐ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	☐ No ☑ Yes, specify number of months **12 months following initial enrollment only.** Explain circumstances when a child would lose eligibility during the time period. • Incarceration • Move out of the state • Eligible for Medicaid • Covered by other health insurance • Eligible for State Employee health coverage • Non cooperation with determination of Medicaid eligibility • Voluntary discontinuance • Factually ineligible at time of approval and still ineligible
Imposes premiums or enrollment fees	☐ No ☐ Yes, how much? Who Can Pay? ☐ Employer ☐ Family ☐ Absent parent ☐ Private donations/sponsorship ☐ Other (specify)	☐ No ☑ Yes, how much? Premium: 1 Child enrolled income 150-175% FPL $10 income 175-200% FPL $15 2 or more children enrolled income 150-175% FPL $15 income 175-200% FPL $20 Who Can Pay? ☐ Employer ☑ Family ☐ Absent parent ☐ Private donations/sponsorship ☐ Other (specify)
Imposes copayments or coinsurance	☐ No ☐ Yes	☐ No ☑ Yes $5 for non-emergency use of the emergency room

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Provides preprinted redetermination process	☐ No ☐ Yes, we send out form to family with their information precompleted and: ☐ ask for a signed confirmation that information is still correct ☐ do not request response unless income or other circumstances have changed	☑ No ☐ Yes, we send out form to family with their information and: ☐ ask for a signed confirmation that information is still correct ☐ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The intake applications and renewal applications are both processed similarly, however there is one unit that processes the renewal applications and eight units that process intake applications. When processing a renewal there are several factors that do not have to be reverified such as citizenship. The renewal application is also shorter. It is only one page as opposed to the intake application that is five pages long.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 **As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

140%	of FPL for children under age	1
133%	of FPL for children aged	1-5
100%	of FPL for children aged	6-18

Medicaid SCHIP Expansion

_____	of FPL for children under age	_____
_____	of FPL for children aged	_____
_____	of FPL for children aged	_____

Separate SCHIP Program

200%	of FPL for children under age	0-18
_____	of FPL for children aged	_____
_____	of FPL for children aged	_____

6.2 **As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income?** *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

☐ Yes ☒ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	**Medicaid SCHIP Expansion**	**Separate SCHIP Program**
Earnings	Student: entire earned income. Others:$ 90 (or entire earned income, whichever is less)	N/A	$ 0
Self-employment expenses	All verified expenses	N/A	All expenses claimed on Federal Income Tax return or verified expenses if no return was filed or if filed return is not representative
Alimony payments			
Received	$ 0	N/A	$ 0
Paid	$ 0	N/A	$ 0
Child support payments			
Received	$ $50 per child	N/A	$ 0
Paid	$ 0	N/A	$ 0
Child care expenses	$ $200 maximum	N/A	$ 0
Medical care expenses	$ 0	N/A	$ 0
Gifts	$ 30 per person during a 3- month period	N/A	$ 0
Other types of disregards/deductions (specify)	All income required by law that established the benefit or by Title XIX to be disregarded	N/A	All income required by federal law that established the benefit to be disregarded

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

☒ No ☐ Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

N/A ☐ No ☐ Yes, specify countable or allowable level of asset test _____

Separate SCHIP program

☒ No ☐ Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____

N/A ☐ No ☐ Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2001?

☒ Yes ☐ No

On October 1, 2001, the required waiting period for a child whose health insurance coverage was voluntarily canceled was reduced from 6 month to 3 months. The waiting period was waived for children with serious or chronic illnesses.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage.

AHCCCS is currently finalizing a waiver proposal for SCHIP parents.

B. Employer sponsored insurance buy-in.

AHCCCS is currently reviewing the possibility of a pilot program.

C. 1115 waiver

NC

D. Eligibility including presumptive and continuous eligibility

Not Applicable

E. Outreach

- AHCCCS has hired a manager for the four KidsCare outreach staff. This manager represented the interest of the outreach staff at meetings with the marketing firm Genesis, and has been instrumental in development of materials, and overseeing large projects such as the 381 school district campaign. The manager has overseen the promotion of the pilot projects, such as business and hospitals, and has developed tracking systems for outreach activities. Regular meetings are conducted with outreach staff, providing updates on KidsCare policy, office procedures, and reviewing the needs of the outreach staff. The manager also attends KidsCare management meetings and monitors the impact outreach projects will have on eligibility processes and staff. The manager also works closely with the Community Relations Administrator. The manager plans to work with the outreach staff in their respective areas, to review their trainings, presentations, and to provide support in rural areas.
- AHCCCS and the Department of Education (DOE) partnered to notify families of the KidsCare program through the Child Nutrition Program. AHCCCS printed and sent one million flyers to 381 school districts that participate in the Child Nutrition Program. Families completed the simple form, answering three self-screening questions and returned it to the school if their child was uninsured, and they wanted an application mailed to them. The schools have been submitting the flyer to the KidsCare office for follow-up. To date AHCCCS has received 18,274 requests for applications from 86 school districts and has approved 1323 children for health insurance. AHCCCS plan to explore further methods to reach children through the schools.
- AHCCCS plans to:
  - Expand its outreach with small businesses. We are developing a flyer for businesses and are planning to do a mass mailing to 20,000 to 30,000 small businesses. In addition the outreach staff are currently making contacts by phone

and in person.

- Continue to develop partnerships with various interfaith groups. We will be offering training for applications, and promoting increased involvement within their communities to enroll and promote KidsCare.
- Expand the use of the self-screening flyer at immunization events.
- Work with businesses, physician's offices, dental offices, hospitals, and any other sites that will display posters, and brochures.
- Work with the Child Care Agency and HUD to explore methods that can reach the clientele within their agencies.
- Work with Libraries asking them to display posters and brochures and adding that they can use the Internet to obtain an application.
- Work with the Native American community in their chapter houses and swap meets to promote enrollment and to communicate the benefits of being on KidsCare.
- Work closer with hospitals to reach the "treat and release" emergency and urgent care patients.

F. Enrollment/redetermination process

AHCCCS submitted a state plan amendment to CMS for FFY 2001. This amendment permits Arizona to accept the parental declaration of income for the KidsCare program. This was implemented in October of 2000. Accepting the members declaration of income not only expedites the enrollment process, it also greatly reduced the number of children who are denied KidsCare for failure to provide information. The average number of children who were denied for failure to provide information per month in 1999 was 867 (30.2%) and in 2000 when we did not require verification for three months the average went down to 673 (21.6%). The average monthly denials for failure to provide information for the first three months of 2001 is 303 (9.7%).

AHCCCS will continue to explore simplifying the initial and renewal applications and the eligibility process.

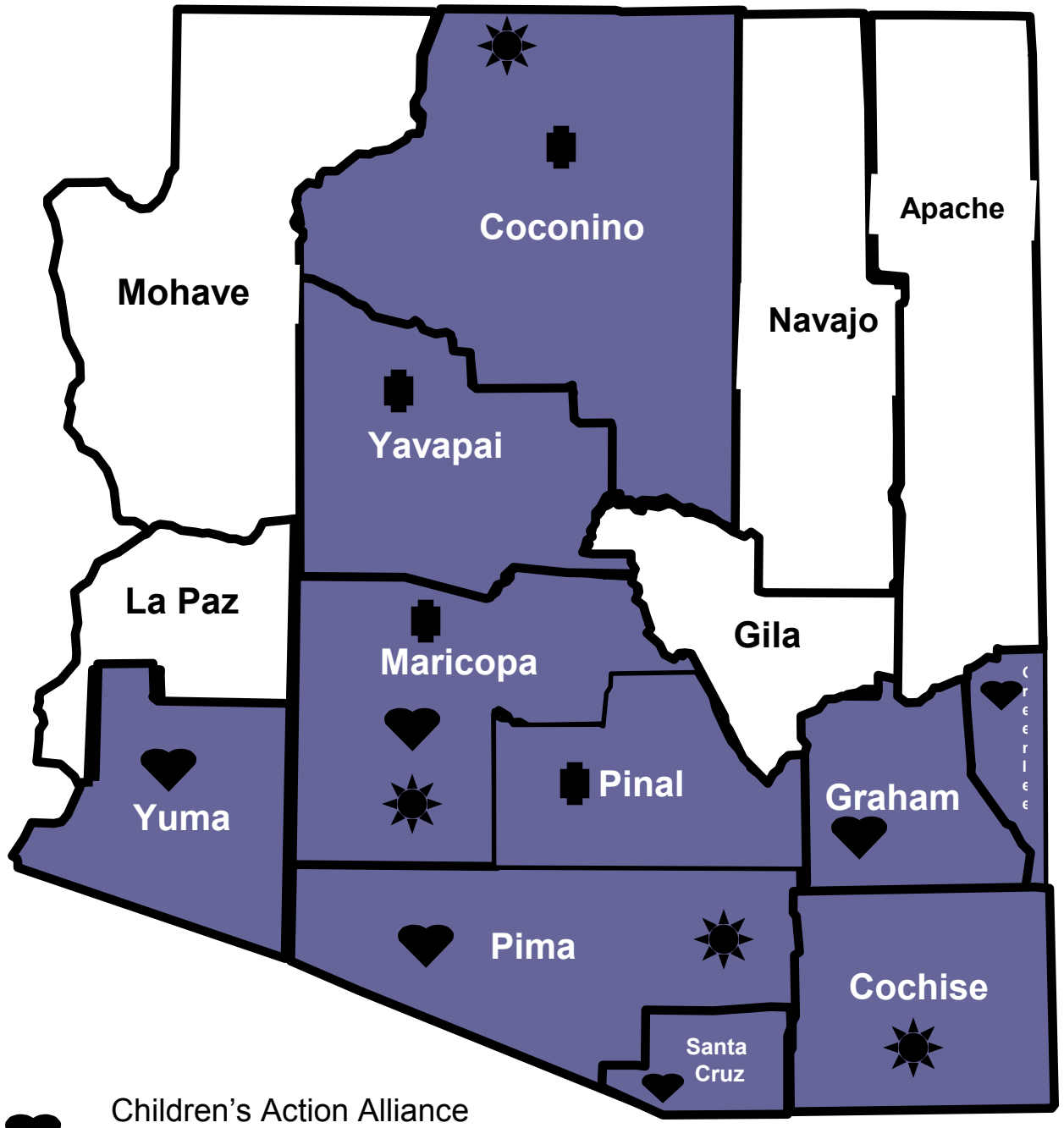
G. Contracting

N/C

H. Other

N/A

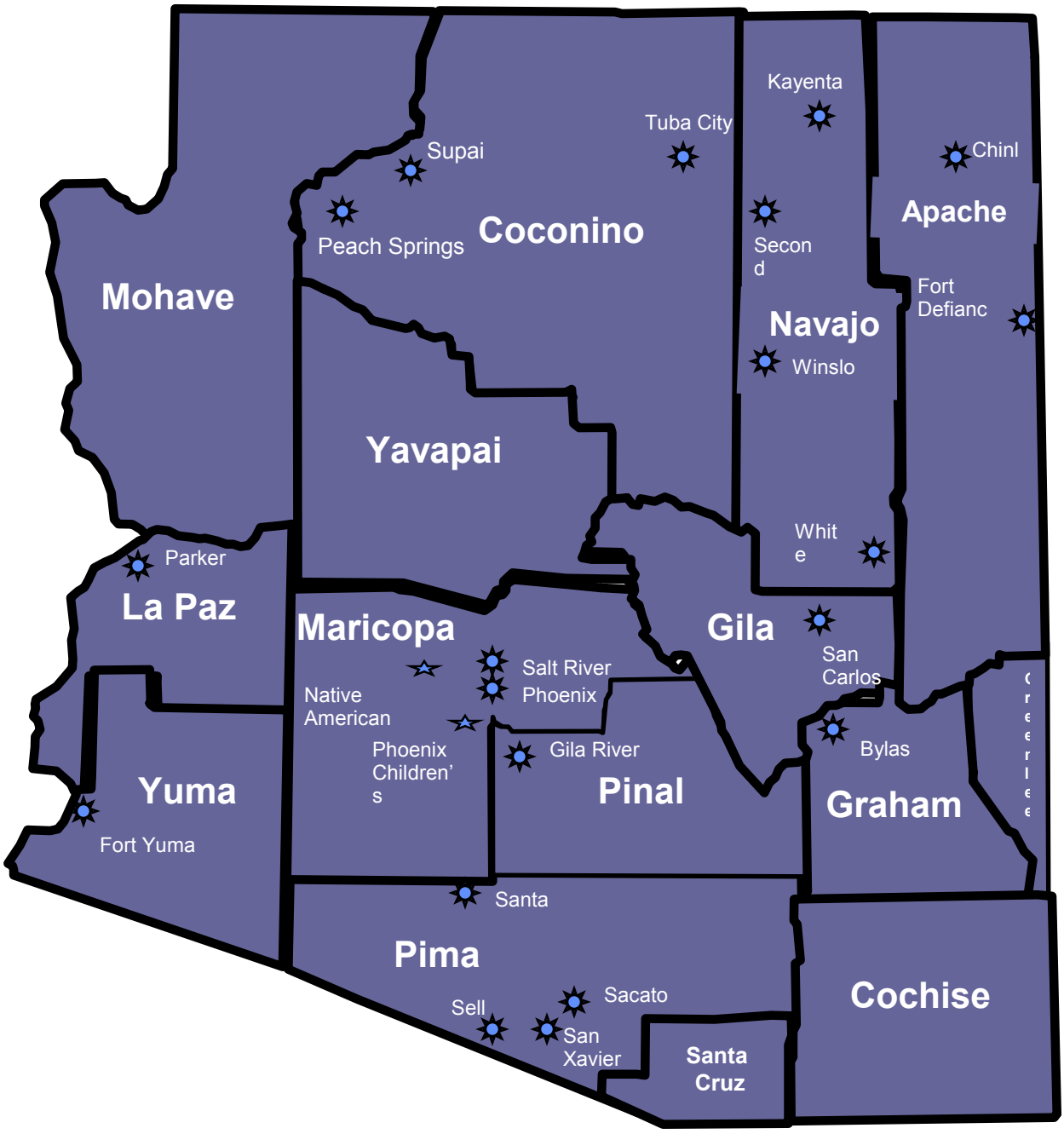
Counties Targeted for KidsCare Outreach by Foundations



Children's Action Alliance
Flinn Foundation
St. Luke's Health Initiative

AHCCCS Outreach Coordinator:
Anna Alonzo - AMAlonzo@ahcccs.state.az.us
801 East Jefferson, MD 4100
Phoenix, Arizona 85034
Phone: (602) 417-4736 Fax: (602) 252-6536

IHS FACILITIES and OTHER ENTITIES THAT TARGET KIDSCARE POPULATION



IHS Facility

Other Entity

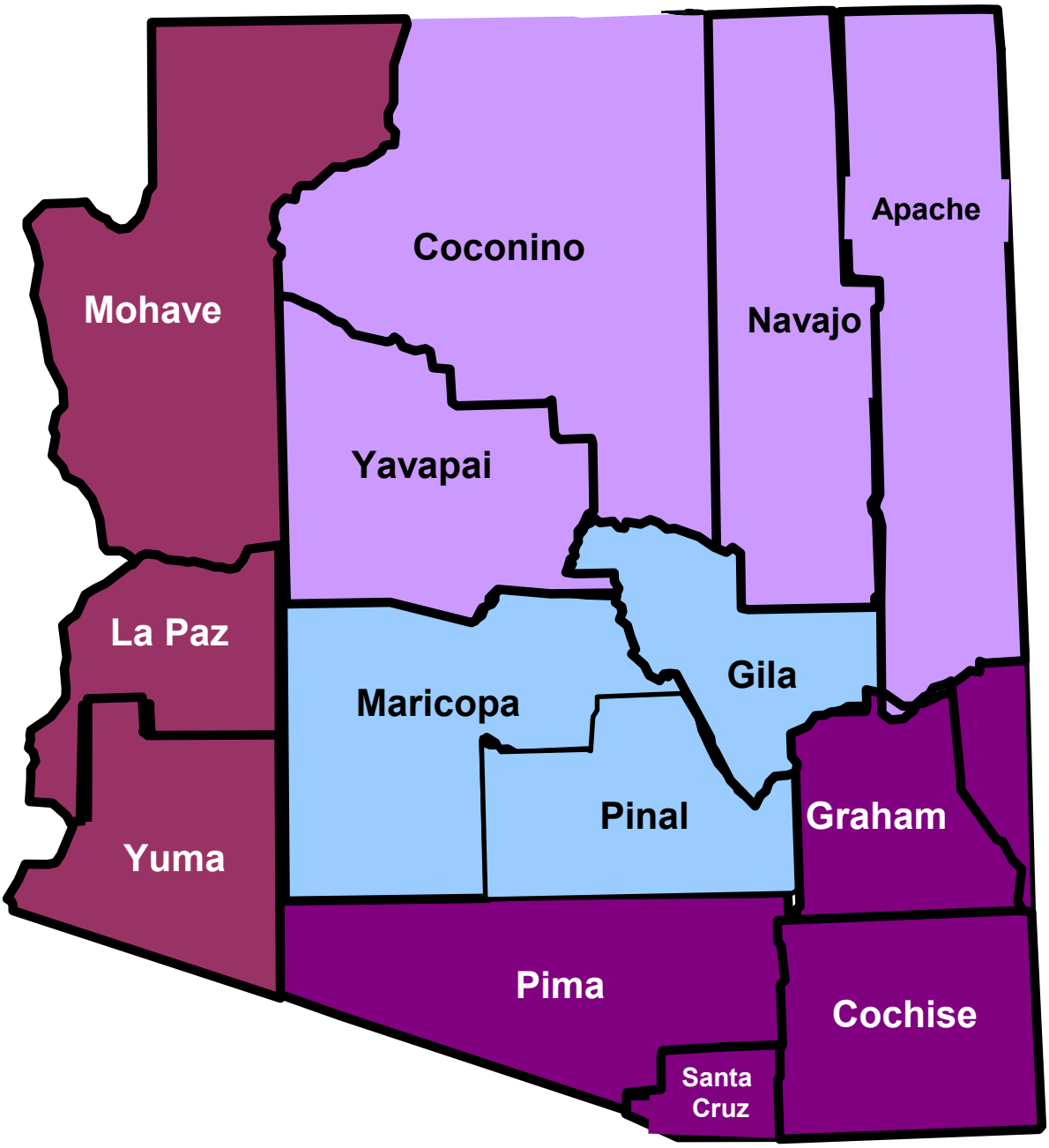
Native American Coordinator: Julia Ysaguirre
801 East Jefferson Street, MD 4200
Phoenix, Arizona 85034
Phone: (602) 417-4610 Fax: (602) 256-6756

Partnership for Arizona's Families
2001/02 Grantees by Location

COVERED BY COMMUNITY BASE ORGANIZATIONS (CBO) OUTREACH

NOT COVERED BY CBO OUTREACH

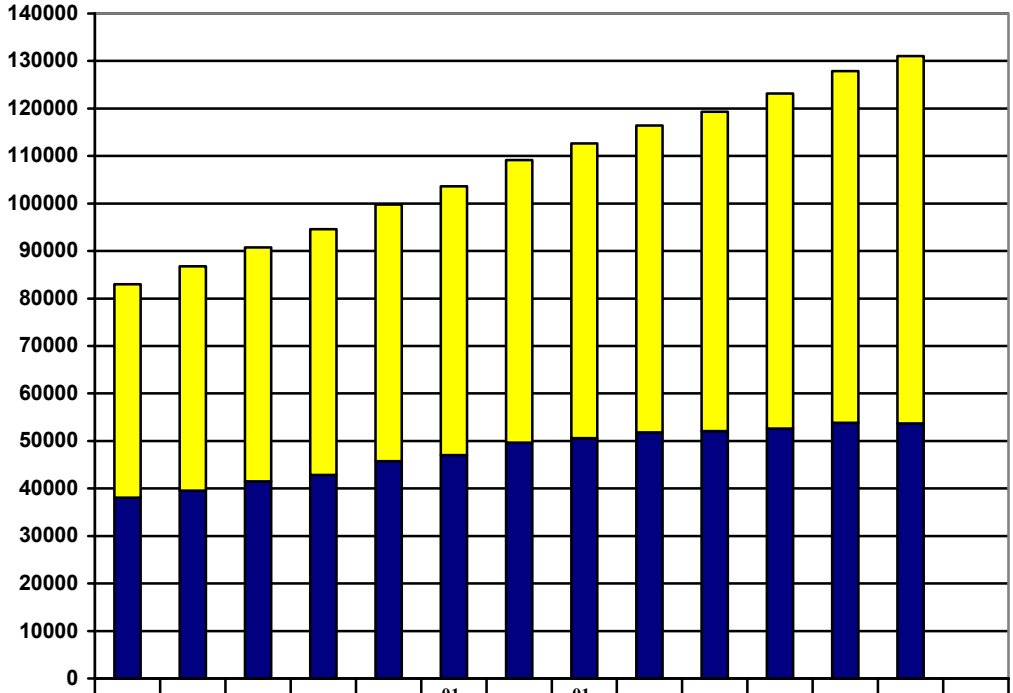
AHCCCS KIDSCARE OUTREACH REGIONS



Central Arizona - Eric Dow - **417-5447**
Northern Arizona - Gloria Groves - **928-520-4104 ext. 1068**
Southern Arizona - Heidi Esposito - **520-205-8609**
Western Arizona - Yolanda Cazares - **520-782-0776 ext. 1206**

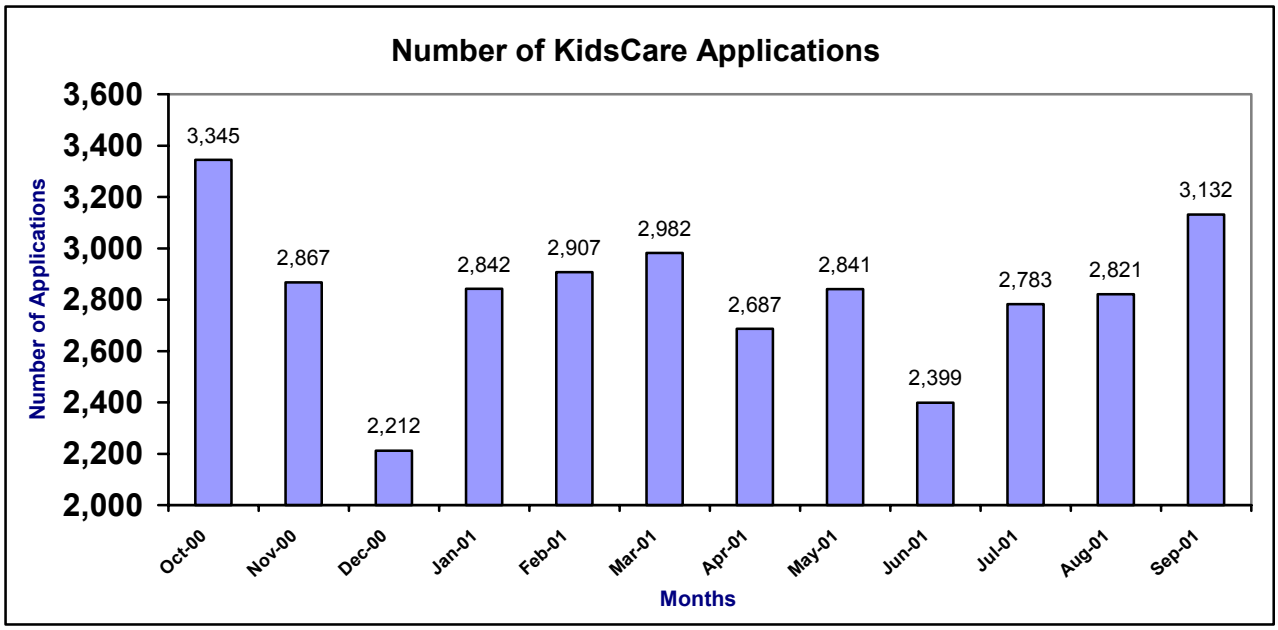
Attachment B

Total Kids Enrolled for Health Coverage due to KidsCare Applications



	00-Oct	00-Nov	00-Dec	01-Jan	01-Feb	01-Mar	01-Apr	01-May	01-Jun	01-Jul	01-Aug	01-Sep	01-Oct
Totals	82979	86758	90759	94573	99793	103618	109151	112660	116397	119288	123161	127871	131047
Medicaid Enrollment due to KidsCare Applications	44906	47208	49257	51698	54033	56603	59508	62064	64559	67188	70528	74048	77362
KidsCare Only	38073	39550	41502	42875	45760	47015	49643	50596	51838	52100	52633	53823	53685

This table is generated form monthly AHCCCS enrollment figures as of the first day of each month.

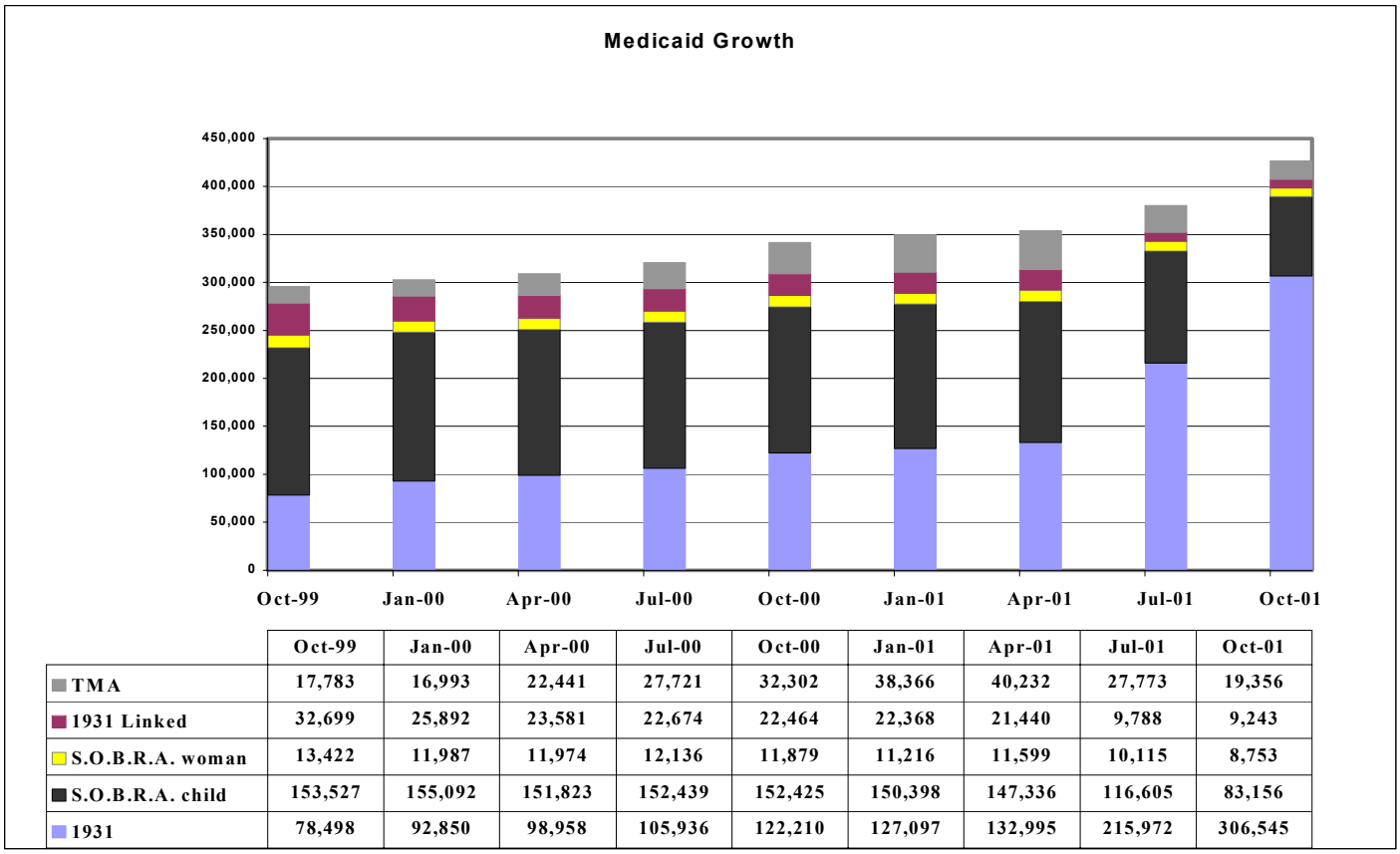

Number of KidsCare Applications
Number of Applications
3,600
3,400
3,200
3,000
2,800
2,600
2,400
2,200
2,000
3,345
2,867
2,212
2,842
2,907
2,982
2,687
2,841
2,399
2,783
2,821
3,132
Oct-00
Nov-00
Dec-00
Jan-01
Feb-01
Mar-01
Apr-01
May-01
Jun-01
Jul-01
Aug-01
Sep-01
Months

Attachment D

Contributing Factors Medicaid Growth

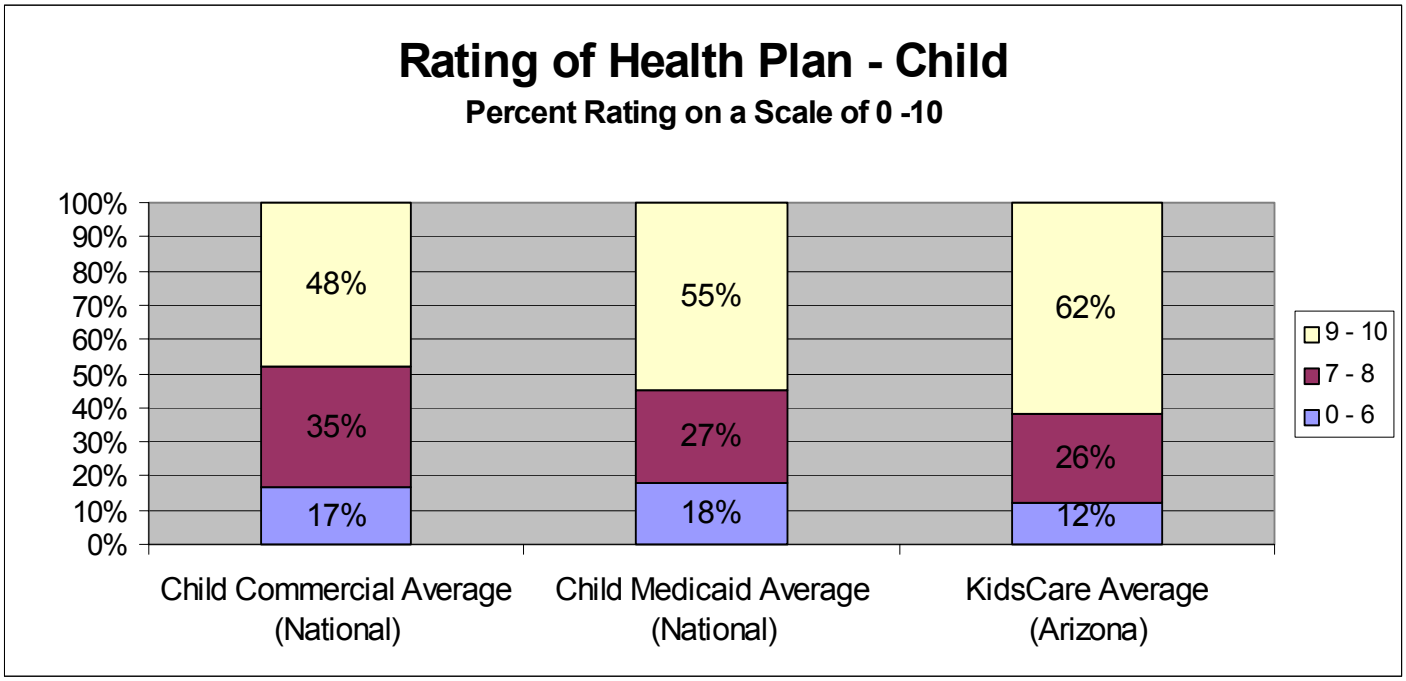
Introduction:
There has been a growth of approximately 38 percent in the total AHCCCS population since October 1999. The total population as of October 1, 1999 was 473,921 as compared to 657,231 as of October 2001. The largest growth in the population involves the programs for families, children and pregnant women for which determines eligibility. The members qualifying under these programs increased from 295,929 in 10/01/99 to 427,053 as of 10/01/01, a two-year increase of 131,124 members or 43%.

Families with children qualifying under Section 1931 of the Social Security Act experienced the greatest increase, from 78,498 to 306,545. A substantial part of this increase reflects the transfer of members from S.O.B.R.A., Transitional Medical Assistance and 1931 related groups resulting from the increase in the income limit for 1931 on July 1, 2001. 31,507 members were added as a direct result of the change.



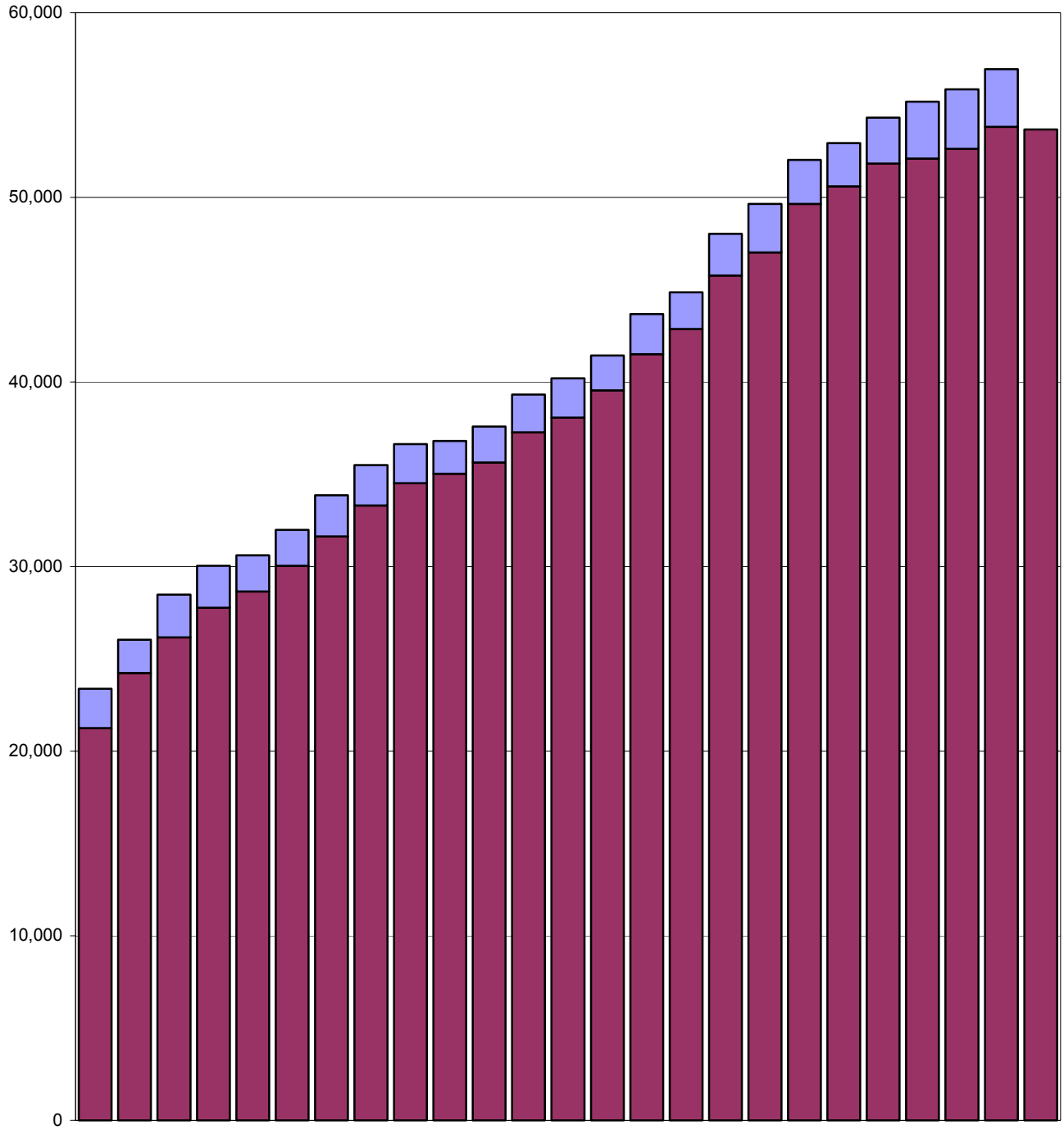
	Oct-99	Jan-00	Apr-00	Jul-00	Oct-00	Jan-01	Apr-01	Jul-01	Oct-01
TMA	17,783	16,993	22,441	27,721	32,302	38,366	40,232	27,773	19,356
1931 Linked	32,699	25,892	23,581	22,674	22,464	22,368	21,440	9,788	9,243
S.O.B.R.A. woman	13,422	11,987	11,974	12,136	11,879	11,216	11,599	10,115	8,753
S.O.B.R.A. child	153,527	155,092	151,823	152,439	152,425	150,398	147,336	116,605	83,156
1931	78,498	92,850	98,958	105,936	122,210	127,097	132,995	215,972	306,545

Attachment G



Key:

0-6	**Fair Rating**
7-8	**Good Rating**
9-10	**Very Good Rating**



	Oct-99	Nov-99	Dec-99	Jan-00	Feb-00	Mar-00	May-00	Jun-00	Jul-00	Aug-00	Sep-00	Oct-00	Nov-00	Dec-00	Jan-01	Feb-01	Mar-01	Apr-01	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01
* Title XIX	2125	1804	2320	2281	1952	1951	2193	2123	1775	1941	2042	2121	1882	2171	1986	2262	2635	2391	2476	3088	3225	3130	0
KidsCare	21,25	24,23	26,15	27,76	28,65	30,03	33,30	34,51	35,03	35,64	37,27	38,07	39,55	41,50	42,87	45,76	47,01	49,64	51,83	52,10	52,63	53,82	53,68